Eating Disorders

PRIORY HEALTHCARE

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A REAL AND LASTING DIFFERENCE FOR EVERYONE WE SUPPORT

Video – by G Slayen

Click here for Youtube Link

Eating Disorders

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19 Year old woman

Weight:	23.2 Kg
Height:	173cms
BMI:	7.71
Hb%:	2.1%

Eating Disorders - Presentation

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- Discuss epidemiology and aetiology of ED
- Describe the main Eating Disorders and their symptoms
- Discuss the medical and psychiatric complications of ED
- Describe the treatment of ED
- Discuss outcome of ED

Eating Disorders
- Epidemiology (UK Data)

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Lifetime Prevalence:

AN : 0.9 % - 2.2 % in women
0.2 % - 0.3 % in men

BN : 1.5 % - 2.0 % in women
0.5 % - 0.8 % in men

BED: 3.5 % in women
2.0 % in men

EDNOS: 30 – 60 % of all ED conditions

Undiagnosed cases ?????

Eating Disorders
Types of ED

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- Anorexia Nervosa
- Bulimia Nervosa
- Binge Eating Disorders
- EDNOS
- ? Obesity

Anorexia Nervosa

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Clinical Features

- Intentional Weight loss
- Fear of fatness
- Disturbance of body image
- Endocrine disturbance

Types

- Restrictive
- Binge-eating/purging

BULIMIA. TWICE THE TASTE, NO CALORIES.

Cyanide and Happiness © Explosm.net

Bulimia Nervosa

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Clinical Features

- Recurrent binge episodes (at least twice a week for 3 months)
- Persistent desire and compulsion to eat
- Compensatory behaviour e.g vomiting, purging, starvation and use of drugs
- Fear of fatness

Types

- Purging Type
- Non-purging Type

Binge Eating Disorder

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Binge Eating Disorder

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- Recurrent episodes of binge (two episodes a week for 6 months)
- Binging until physically feeling full, eating rapidly during binging, eating alone etc.
- Fear of binge eating rather than fatness

Other Types

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Eating Disorder Not Otherwise Specified (EDNOS): those patients whose quality of life severely affected by disturbed relationship with food but do not meet the criteria for one of the other ED

- Atypical AN and BN

Obesity

Aetiology- Different Models

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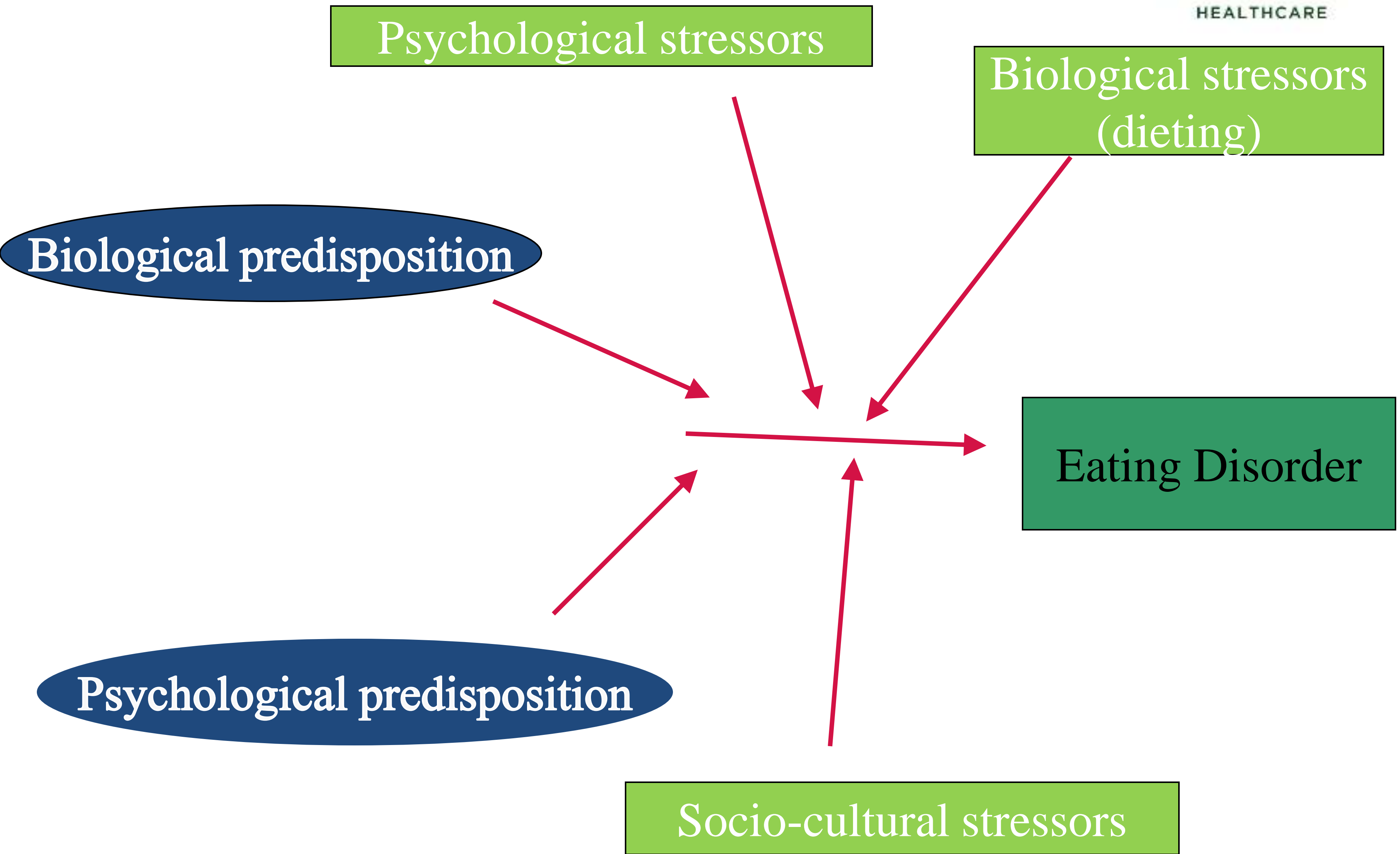
- Psychodynamic model - ED symptoms are just a smoke screen
- Cognitive and behavioural model – self esteem linked to body weight
- Biological model – Addiction to endogenous opioids
- Systemic model – Enmeshed family relationship
- Complexity model – combination of the above models and fractal sub model explains patterns



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Some celebrities…

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Video – Dove Real Beauty

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32555_doverealbeauty.wmv

Psychiatric co-morbidity

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	AN	BN
• Depressive symptoms	+	+++
• Anxiety symptoms	+	++
• Obsessional symptoms	++	+
• Impaired concentration	+++	+++
• Social withdrawal	+++	+
• Substance misuse	-	+
• Negative self-evaluation	++	++
• Perfectionism	++	++
• Impulsivity	-	+

Treatment of Eating Disorders

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Physical Monitoring

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- Appearance and Behaviour
- Body Mass Index
- Eating Disorder specific symptoms
- Blood Tests including ECG
- Corroborative History

Appearance and Behaviour

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- Looking tired and exhausted
- Sleep disturbance (altered sleep pattern)
- Reduced alertness
- Cognitive rigidity (narrowing of the range of topics in the conversation)
- Beware of splitting, idealisation

Body Mass Index

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- 17.5 – 15.0 : Usually frequent blood tests are not necessary, could be done as and when required
- 15.0 - 13.5: Needs at least fortnightly blood tests.
- <13.5 : Weekly blood tests.

The above criteria are for general guidelines only.

Duration of the BMI, patient specific factors, rate of weight loss or gain will modify the criteria

Rapid Weight Gain

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- It is safe to achieve 0.5 Kg weight gain per week in the community. 0.5 – 1.0 Kg weight gain in in-patient setting.

- If the weight gain is faster than this more chance for ‘Refeeding Syndrome’

Refeeding Syndrome

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- Definition of Refeeding Syndrome

" set of symptoms occurring as a result of mismatch between rate of use of nutrients, availability from the body reserve and external supply of refeeding"

- Any nutrient can be affected
- Death usually due to K, Mg & Po4
- Aim is to prevent, if not early detection and treatment according to protocol

Symptoms- Eating Disorder specific

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Certain ED symptoms lead to specific physical Symptoms and blood changes.

Few examples:

- Vomiting: low potassium, dehydration
- Laxative Abuse: low potassium, dehydration, constipation, abdominal cramps, distension
- Excessive Exercise: Weakness, cramps, dehydration, signs of fracture

Medical Complications

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Gastrointestinal	Motility problems
Cardiovascular	Cardiac arrest (hypokalemia)
Electrolyte Disturbances	Hypokalemia, Re-feeding Syndrome
Nutritional Deficiencies	Hypovitaminosis (Vit. B12 and Folate) Hypoglycaemia, low albumin
Endocrine	Amenorrhoea (osteoporosis)
Blood	Nutritional Anaemia, agranulocytosis

Investigations

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- **Blood Tests:**

Baseline: FBC, U & Es, LFT, TFT, Vit. B12 and Red blood cell Folate, Magnesium and Phosphate.

Follow-up: usually U & E, LFT, Serum Magnesium and Phosphate

- **ECG in selected patients**

- **Bone scan (Dexa Scan)**

Treatment of Bulimia

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Treatment of Bulimia

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- Short term psychotherapies
- Psychoeducation
- Brief "guided self help"
- Antidepressant drugs
- Medication should not be used as the sole or primary treatment
- co-morbid conditions may be resolved with weight gain alone

Treatment of Anorexia (1)

- 0.5-1 kg of weight gain in inpatients and 0.5 kg in outpatients
- Regular physical monitoring
- Use of multivitamins in some cases
- Total parental nutrition – only when significant gastrointestinal dysfunction is present
- Patients to be informed of risk
- Expert involvement in the treatment

Treatment of Anorexia (2)

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Psychological Interventions

- Some randomised control studies, most recommendations based on Opinions
- CBT
- IPT
- Focal psychodynamic therapy
- Family interventions for adolescents

Prognosis & Outcome

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PROGNOSIS
(10 year FU after clinical referral)

	AN	BN
Death	10%	≅1%
Persisting index disorder	10%	10%
Subthreshold disorder	15%	20%
Crossover	15%	≅1%
No clinical ED	50%	70%

Poor prognosis indicators:

- Longer duration of illness
- Previous treatment
- Lower minimum weight
- Personality and social difficulties
- Distorted family relationships
- Purging subtype
- Later age of onset
- Comorbidity

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19 Year old woman

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Workshop

Case Scenario 1:

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- A patient who has been suffering from anorexia nervosa reported to you that she has a swelling in her left ankle. On examination the swelling is confined to left foot and there is no generalised oedema. Patient is able to walk with some pain. She is worried that she is not able to do her usual amount of exercise and she might gain weight as a result of this.

What other information you would require?

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- How did the swelling come about?
- Weight to calculate BMI
- History of amenorrhoea
- Details of exercise

What are the differential diagnoses?

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- Pathological fracture secondary to amenorrhoea
- Stress fracture
- Soft tissue injury

How will you investigate further?

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- X-ray
- DEXA Scan
- Ultrasound of Calcaneum
- MRI

How will you manage?

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- Rest Vs fear of gaining weight
- Improving nutrition (use this to enhance patient's motivation)
- Role of Calcium, Vit. D, Oral Contraceptive Pills
- ? IGF-1, DHEA, and bisphosphonates

Case Scenario 2 :

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- A patient who is recently referred to a specialist eating disorders unit developed headache, tiredness and palpitations. On examination there is evidence to suggest that her legs are swollen.

Her weight has increased from 32 Kgs (BMI 13.6) to 36 Kgs (BMI 14.1). She has been working hard to improve her dietary intake by following the meal plan set by her mother and herself.

What other information will you ask for?

- Rate of weight gain
- Details of the actual diet
- Any other physical symptoms

What are the differential diagnoses?

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- Refeeding Syndrome
- Isolated electrolyte abnormality
- Imbalance in the diet (less protein intake than required)
- Water loading

How will you investigate further?

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- Blood tests. Specifically look for Mg, K and Phospahte
- ECG
- Renal function test (increased GFR and decreased urea and creatinine)

How will you treat?

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- Treatment of refeeding syndrome:
- Prevention: Balanced diet, sensible weight gain
- Regular blood tests (frequency depends on the clinical situation and previous blood test results)
- Treat hypokalemia, hypomagnesemia and hypophosphataemia as necessary
- Chance for refeeding syndrome to develop lessens when BMI > 15.0

Case Scenario 3 :

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- A patient has presented in the specialist eating disorder clinic with symptoms of distension in the stomach, difficulty in swallowing. On examination her abdomen is distended but soft, no mass palpable and bowel sounds are sluggish. She hasn’t opened her bowels for more than a week. There is no pain and the rectal examination is unremarkable.

What other information you will ask for?

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- History of use of laxative- how many, what type, recent reduction or cessation
- Previous bowel habits

- History of vomiting

How will you investigate further?

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- ? X-ray Abdomen
- Barium enema/ colonoscopy

What are the differential diagnoses?

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- Constipation secondary to laxative withdrawal
- Cathartic or atonic colon
- Irritable bowel syndrome
- Defaecatory disorders (rectocele)
- Slow transit constipation (normal in young women)

How will you manage?

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- Management of Laxative abuse:
- Key is to relieve constipation
- Recommence laxatives at the usual dose. Gradual withdrawal to avoid constipation.
- Look for electrolyte changes and oedema.
- Adhere general principles- adequate water and fibre intake etc.

Case Scenario 4 :

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- A woman in her early forties, was diagnosed for the first time with Bulimia nervosa – binge-purge subtype. Her eating disorder symptoms follow a pattern of few days of starvation followed by few days of binging. During binging she will have more 4000 calories everyday. She tried to make herself sick but couldn't do it always. Hence she relies on laxatives to control her weight. It is not very successful and she has gained more 10 Kg in the past one year. She was recently diagnosed to have Type II diabetes mellitus which prompted her to take control of binging and weight gain.

What other information you would require?

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- More detail on her eating disorder e.g frequency and timing of vomiting, night-eating, type of food she binges on (food rich in carbohydrates)
- Details of her diabetes e.g use of antidiabetic medications, any other drugs
- Family history of diabetes (aim is to understand the link between diabetes and bulimia)

How will you investigate further?

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- Serial blood tests to monitor the control of diabetes
- Appropriate investigations to identify and treat DM complications
- Don’t forget to do blood tests especially K to identify hypokalemia due to vomiting and electrolyte abnormality of laxative abuse.

What psychoeducation will you offer?

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- Dangers of vomiting e.g cardiac arrest, useless nature of laxatives in controlling weight
- To help the patient to understand the link between binging- weight gain- onset of Type II diabetes mellitus.
- Use weight gain and DM to motivate her but carefully.

Case Scenario 5 :

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- A 19 year old girl presents to you with symptoms of anorexia nervosa (BMI 15.6, amenorrhoea, body image distortion and fear of fatness). She came in with the mother who recently found her using a tablet which she bought from the internet. It was sold as a magic pill to help losing weight. Later they found that the tablets contained 'thyroxine' as its main constituent. It was the mother who brought the patient to your clinic.

What other information you will ask for?

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- Aim is to find whether she is in hypo or hyperthyroid state (Is she still taking it?)
- Any physical symptoms apart from weight loss
- Does the tablet contain any other chemicals e.g amphetamine

What further investigation you will ask for?

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- Urine analysis
- Electrolytes e.g hypokalemia is very common.
- TSH and free T3 or Free T4 to confirm hyperthyroidism
- TSH and free T4 to confirm hypothyroidism
- TRH is rarely done (to differentiate TSH resistance)

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The girl's mother asks whether 'thyroid' really makes her daughter lose weight? (Her mother is a doctor)

The answer in short is yes due to the following reasons: Thyroid hormone can increase:

- Heart rate and cardiac output thereby demanding more energy diverted to this vital organ
- bone turnover
- Gut motility resulting in reduced absorption
- Muscle protein turnover
- Glycolysis and lipolysis
- But ? ....

How will you manage?

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- Manage thyrotoxicosis factitia (stop self administration, propranolol 40 – 80 mg, carbimazole ?. Treat thyroid crisis as medical emergency with propranolol, potassium iodide, steroids etc)
- Watch for rebound hypothyroidism and treat as usual.
- Beware that TSH may remain suppressed for months. May need to rely on T3/T4.

How will you manage?

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- Manage bulimia nervosa as usual
- Usually joint management by diabetic specialist and psychiatrist is necessary.
- Information about patient's behaviour e.g skipping antidiabetic medication with the view to 'burn-off' excess calories, should be clearly communicated between professionals.
- Psychoeducation , motivational enhancement (onset of DM made patient to ask for help)

Thank you!

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